MRI COVID Questionnaire

Name: ___________________________  Date of birth: ___________________________

Today’s date: _______________________

Please read the following questions carefully. It is very important for us to know if you might have Covid. If you do not understand a question, please ask us to explain! If you answer yes to any question, please contact the principal investigator.

1. Yes ☐ No ☐ Do you have COVID?
2. Yes ☐ No ☐ Have you been around anyone recently who has Covid?
3. Yes ☐ No ☐ Did you have a fever?
4. Yes ☐ No ☐ Do you have chills?
5. Yes ☐ No ☐ Do you have night sweats?
6. Yes ☐ No ☐ Do you have a cough?
7. Yes ☐ No ☐ Do you have shortness of breath?
8. Yes ☐ No ☐ Do you have muscle pain?
9. Yes ☐ No ☐ Do you have joint pain?
10. Yes ☐ No ☐ Do you have a headache?
11. Yes ☐ No ☐ Do you have diarrhea?
12. Yes ☐ No ☐ Do you have eye pain?
13. Yes ☐ No ☐ Do you have a recent change or decrease in sense of smell?
14. Yes ☐ No ☐ Do you have a recent change or decrease in sense of taste?

_________________________________________________  Date: __________________________

Signature: ____________________________________________  Date: __________________________